SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

Speech-Language Pathology Out Patient Referral

Please fax completed forms to (705) 759-3692

Name: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

Contact Person/SDM and Phone Number: _____

Please ensure that all relevant sections and information are complete to prevent delays in processing this referral. Please attach any test results or notes that may be of importance to the Speech-Language Pathologist.

Relevant Medical History:

DYSPHAGIA

☐ Modified Barium Swallow assessment (MBS). *Clinical bedside swallowing assessment may be completed, at SLP discretion, if MBS unable to be performed.*

Reason for referral:

HEAD AND NECK CANCER PROTOCOL

☐ Includes: Clinical Bedside Swallow Assessment
Pre and Post Treatment Modified Barium Swallow Assessment (MBS)
Voice and Speech Therapy as per best practice

Relevant information:

SPEECH/LANGUAGE

☐ Speech/Language referral: (*must be acute - within 6 months)*

Reason for speech/language referral:

Referring MD signature: _____ Date of referral _____